

**CLARITY COUNSELING, INC.
CONTACT INFORMATION SHEET**

(Please keep Clarity Counseling, Inc. updated if there are changes to the information in this packet)

BASIC INFORMATION

Full Name: _____

Date of Birth: _____

SSN: _____

Full Address: _____

Phone: _____

Email Address: _____

MEDICAL INSURANCE INFORMATION

Medicaid (Specify Provider): _____
Medicaid Number: _____

Medicare (Specify Provider): _____
Medicare Number: _____

Other (Specify Provider): _____
Member Number: _____

Primary Care Doctor's Name: _____
Phone Number: _____

EMERGENCY CONTACTS

Name, Relation, and Number: _____

Name, Relation, and Number: _____

CLARITY COUNSELING, INC.
YOUTH INTAKE FORM

Parent or Legal Guardian is asked to complete this form for any youth under the age of 18 in order to expedite the counseling process. This information will remain confidential.

Date: _____

Youth's Name: _____

SSN: _____

DOB: _____

Religious Background: _____

Gender: _____

Youth's Family Member Information (include name, age, and type of relationship the family member has with the youth):

Father: _____

Mother: _____

Sibling: _____

Sibling: _____

Sibling: _____

Others: _____

Youth's Educational Background:

Current School: _____ Teacher: _____ Grade Level: _____

Average Grades: _____ Any Behavior Concerns: _____ If yes, describe _____

How does the youth get along with peers? _____

Does the youth have an Individual Education Plan? _____ If yes, what is it for? _____

Legal History:

Has the youth ever been arrested? _____ If yes, indicate arrested for what and when: _____

Developmental History: Does the youth have any developmental delays? _____ If yes, describe _____

Trauma History: Has the youth experienced past trauma? _____ If yes, describe _____

Medical History: Does the youth have any medical issues? _____ If yes, describe _____

Date of last medical exam: _____ Medical Doctor & Phone #: _____

Psychiatric History: Has the youth attended counseling previously? _____ If yes, describe _____

Psychotropic Medications: Is the youth currently taking any psychotropic medications? _____ If yes, describe (current and past medications) _____

Alcohol/Drug Usage: Does the youth currently use alcohol or drugs? _____ If yes, describe (e.g., types, frequency, past history): _____

Suicide Risk: Has the youth ever thought about or tried to hurt himself/herself? _____

If yes, when? _____ How many times? _____

How or what did the youth plan to do? _____

What were the circumstances at the time? _____

Has anyone close to the child/youth ever committed suicide? _____ If yes, describe _____

Abuse History: Has the youth ever been physically, emotionally, or sexually abused? _____ If yes, describe _____

Circle the following symptoms/behaviors that the child/youth has experienced in the last thirty days:

Sleep Disturbance	Weight Change	Lack of Motivation	Withdrawn
Change in Eating Behavior	Restlessness	Physical Complaints	Easily Annoyed or Irritated
Bedwetting	Uncontrolled Temper Outbursts	Guilt/Remorse/Shame	Cruelty Towards Animals
Nightmares	Uncontrolled/Unprovoked Crying	Lack of Concentration	Feelings of Depression
Generalized Anxiety	Difficulty with Decisions	Specific Anxiety	Panic Attacks
Aggression	Nervousness	Fear	Self-Harming Behavior
Tension	Negativistic		

Others: _____

Support Systems: Does the youth have people that he/she can turn to for support? _____ If yes, describe _____

Strengths: What do you feel are the youth's strengths? _____

Presenting Issues: Briefly explain why the youth is seeking counseling at this time: _____

Topics that may trigger the youth during the intake: _____

Goals: What do you hope to achieve through counseling? _____

Other comments: What else will help to benefit the counseling process? _____

Person Completing the Form: _____

Relationship to the person being referred for counseling: _____

CLARITY COUNSELING, INC.

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Phone: 505-294-2722 * E-mail: claritycounselinginc@outlook.com

CONSENT FOR TREATMENT

STATEMENT OF DISCLOSURE: Ron Olguin Jr. and Tara Sue Olguin both have a master's degree in counseling. They are Licensed Professional Clinical Counselors (LPCCs). Each one has supported people with mental health issues and/or disabilities (MR, CP, autism spectrum, etc.) for over 25 years. They have clinical experience with a wide range of mental disorders, including developmental disorders, various mental illnesses (e.g., mood disorders, delusional disorders, anxiety disorders, personality disorders), and neurological disturbances (including traumatic brain injury). They incorporate various approaches into their clinical work. They commonly use a variety of cognitive and behavioral techniques. They work towards evaluating someone holistically, to address underlying causes of behavior, and to build upon personal strengths and supports. Additional information can be shared during the initial appointment.

I, _____, am authorized
(PLEASE PRINT FULL NAME AND GUARDIANSHIP STATUS, IF APPLICABLE)

to consent to treatment for _____.
(PLEASE PRINT FULL NAME OF SERVICE RECIPIENT)

As part of the therapeutic process, I understand that the following shall occur: clinical assessment (which may involve in-person interviews, phone calls, and document reviews), development of a treatment plan and related recommendations, and therapy sessions.

To acknowledge that you agree with each statement below, please place and "X" in each box.

- I have been informed about confidentiality (and limits thereof) and privacy (HIPAA) and how it relates to counseling services received through Clarity Counseling, Inc.
- I authorize Clarity Counseling, Inc. to bill my insurance, as applicable.
- I have received information about the therapeutic process (including intake and discharge), scheduling, cancelations, and emergency situations.
- I understand that Clarity Counseling, Inc. (CCI) is unable to accept Medicare. CCI is currently accepting a few insurance plans and private pay.
- I hereby authorize Clarity Counseling, Inc. to provide therapeutic services to the service recipient indicated above, including assessment, treatment, and referral (as deemed clinically appropriate).

Signature

Date

**RECEIPT AND ACKNOWLEDGMENT OF
NOTICE OF PRIVACY PRACTICES**

Service Recipient: _____

Date of Birth: _____ Social Security Number: _____

I hereby acknowledge that I have received and been given an opportunity to read a copy of the Notice of Privacy Practices of Clarity Counseling, Inc. I understand if I have any questions regarding the Notice or my privacy rights, I can contact Ron Olguin Jr., Privacy Officer.

Signature of Service Recipient Date

Signature of Parent, Guardian or Personal Representative* Date

Service recipient refuses and/or is not able to sign.

Signature of Clarity Counseling, Inc. Representative Date

** If you are signing as a personal representative of an individual, please describe your legal authority to act for individual (e.g., power of attorney, surrogate healthcare decision maker).*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

A written record of visits will be kept in your file. The record contains identifying information about you. It may also contain clinical information (such as a diagnosis, an assessment of functioning, reports from other people that support you, etc.).

Your rights under the Federal Privacy Standards include, but are not limited to, the following:

- You may request restriction on uses and disclosures of your health information for treatment, payment and healthcare operations.
- You may receive a copy of this information statement if you desire.
- You may request that communication with you be made by alternative means. We will make every effort to honor reasonable requests.
- You may request a copy of your file. This will be arranged unless your therapist feels it would cause harm to you or others if that request were approved. If this circumstance should arise, a Clarity Counseling representative will review your file with you.
- We will notify you of individuals who have been given access to your information based upon your written release.

CLARITY COUNSELING INC.:

- Will keep all of your information private. Reasonable environmental and administrative safeguards are in place to meet this objective.
- We will train clinical and administrative personnel regarding your rights to privacy and confidentiality.
- We will attempt to mitigate any breach of your privacy and confidentiality to the best of our ability

The effective date of this notice is May 15, 2005.

If you desire, you may call our office to receive more information about circumstances where you as well as others may gain access to your information.